NECO INSURANCE LTD.

P.O.Box No. 12271, Nava Durga Bhawan, Anamnagar, Kathmandu, Nepal. Tel.: 4770415,
Fax : 977-1-4770162, Email : info@necoinsurance.com.np, www.necoinsurance.com.np

HEALTH INSURANCE CLAIM FORM

Insured :		
Claim No. :		
Policy No. :		
1	Member :	
	Name :	
	Sr. No. :	
	Date of Birth :	
	Sex :	
	Home Address :	
	Office Address :	
	Post/Relationship of Employee :	
2	**For Claims relating to injury during an accident**	
	i. Date and time of Accident :	
	ii. Place of Accident :	
	iii. Cause of Accident :	
3	**For Claims relating to Illness**	
	i. Details of illness :	
	ii. Date of incapacity or diagnosis	
4	**Medical Attendants**	
	i. Name & Address of Private Doctor	
	ii. Attending Member	
	iii. Name and address of all Surgeons, Anesthetists Specialists, Pathologist, attending Member(s)	
	iv. Name and address of all of Member(s) Ordinary Medical Attendant	

	Details of Claim		
	Please fill up the items under which the benefits are claimed in respect of the above Illness/Accident giving Amount Claimed and enclosing Receipt Bills, Prescriptions and have the certificate completed by the Doctor giving the medical attention in respect of which a claim is going to be made.		
	Benefit No.	**Description of Treatment Received**	**Claim Amount**
5	i.	Room/Bed etc., Nursing Expenses including Nursing Expenses.	
	ii.	Doctors/Anesthesia/Surgeon/Specialist fee.	
	iii.	Surgical operation including Anesthesia charge, Operation Theatre charge and Surgeon's charge for operation, Blood, Oxygen and other related materials and equipment charges including cost of Dialysis/Chemotherapy/Radio Therapy/ Ventilator and similar expenses.	
	iv.	Pathology charge, X-ray, MRI, CT Scan, Angiography and other investigative tests or charges.	
	v	Medicines/Drugs, Injections, Artificial Limbs and Surgical Appliances.	
	vi.	Cost of Physio-Therapy during hospitalization.	
		TOTAL	

I declare that I have/my dependent has suffered the above described injuries/illness and that to the best of my knowledge and belief the forgoing particulars are in every respect true. I also declare that there is no other insurance or other source to cover the items claimed.

…………………………………………….

Signature of Claimant

Name of the Employee concerned :

Date :

MEDCIAL CERTIFICATE TO BE COMPLETED BY MEMBER'S DOCTOR.

I certify that ……………………………………………………………………………………….. was Ill/Injured.

Full Particulars of Injury/Illness :

…………………………..

Signature of Doctor

Registration No. :

Date :